

ENROLLMENT APPLICATION

Please call 800-732-5309 between 8:00 A.M - 5:00 P.M. EST Monday - Friday for telephone assistance. You may fax your enrollment to us at 410-308-7905.

Mail application to:
MEDEX Insurance Services, Inc.
P.O. Box 19056
Baltimore, Maryland 21284

PAYMENT INFORMATION

Method of Payment (circle one):

American Express / VISA / MasterCard / Check enclosed
(payable to MEDEX Insurance Services)

CARD NUMBER: _____

EXPIRATION DATE: _____

CARDHOLDER: _____

SIGNATURE: _____

Remittances accepted in U.S. funds only

FOR OFFICE USE

Payment by: Check / M.O. / Credit Card

Check# _____ Amount _____

Premiums: U.S. Citizens Traveling Abroad:

One months:	\$65.00
Four months:	\$120.00
Six months:	\$160.00
Nine months:	\$195.00
Annual:	\$225.00

Visitors to the U.S.:

Six months:	\$48.00
Annual:	\$60.00

As a condition precedent to MEDEX's liability the Member will upon request execute an agreement to empower MEDEX to obtain relevant medical information from the home physician, to collect due proceeds from insurance or other sources, and undertake to reimburse expenses incurred on the Member's behalf by MEDEX that are not covered under the individual program.

I hereby apply to purchase this program. I represent that the Member meets the Eligibility requirements of this program, and that the above statements and answers are complete and true to the best of my knowledge. I also understand that my answers are the basis of the contract between the Member and the Company, and that any incorrect answers may void this coverage. Enrollment will be effective upon receipt of payment and the completed application. Applications and credit card authorization is hereby made:

Signature of Participant or Guardian

Date

APPLICANT INFORMATION

First Name of Applicant: _____ Middle Initial: _____

Last Name of Applicant: _____

Sex: Male Female Date of Birth: _____

Address: _____
Street Address

City _____ State _____ Zip _____

Home Telephone: _____ Work Telephone: _____

Email Address: _____

Home Country: _____

Host Country: _____

Name of Educational Institution in Host Country: _____

U.S. Citizens Traveling Abroad

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 Four months: \$120.00 Nine months: \$195.00

Visitors to the U.S.

Six months: \$48.00 Annual: \$60.00

Check one: Foreign Nationals Traveling thru the U.S.

U.S. Citizens Traveling Abroad

Coverage Period Requested: _____ thru: _____

Primary Health Insurance Co.: _____

Phone: _____ Policy No.: _____

Person to be contacted in the event of an emergency:

Name: _____

Home Telephone: _____ Work Telephone: _____

Relationship: _____